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ABSTRACT

A new technology, which the authors see developing in the mental health field, is viewed as a consequence of urbanism with its varied societal manifestations. A major part of this technology is the ability to invent special social prostheses and to assemble them into a spectrum of services which represent various levels of intervention: (1) casefinding; (2) outpatient care; (3) partial inpatient care; and (4) total inpatient care. These are described in terms of the persons they should serve. The remainder of the paper deals with the continuity in patient care which would ideally be the coordination of all mental health resources. It is defined as having the right kind of care at the right time. Two dimensions are considered: (1) the relations between organizations; and (2) articulating roles within and between organizations. Sources of resistance to collaboration among services are mentioned. A sanction to mandate such collaboration must come from some community power center. Criteria for coordination and the importance of evaluation are discussed. (TL)

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Toward a New Technology of Mental Health Care

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A new technology is developing in the mental health field, not as an elaboration of older pastoral approaches but rather as a consequence of the recognition of the vast potentialities of city life. Our rural heritage has misinformed us that the complexities of the urban environment cause mental disorders when, in fact, the rate is more or less constant.[1] A new understanding of urbanism allows us purposefully to use its variety and inventiveness.

In the past in the USA and perhaps other places, virtue and calmness were assigned to the countryside and vice and disorder to the cities. The city sent its ill, its aged and its lost children to the country where, even if they did not get better, they did not get worse. Now we are looking for and discovering the virtues of the city state.

The little rural community typically lacks the division of labor, the professionalization and the technology needed for a highly differentiated treatment of mental illness. The approach instead is a kind of benevolent custodialism and the burden of care is shared and diffused within an extended kinship or tribal network. If bizarre behavior arouses too much anxiety among relatives and friends, the mentally ill are sent away to be isolated and insulated[2] in asylums where they are looked after by hired-hand custodians.

Urbanism as a way of life has been accompanied by the growth of the

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helping professions and the division of labor and responsibilities among them. Specifically there is stimulation for the invention of technologies that provide specialized approaches to the treatment of mental illness. Cities, in contrast to rural neighborhoods, can provide for the variety of innovations and the concentration of resources now understood to be necessary for dealing with mental health problems. One may note, for example, that England and the Netherlands, both highly urbanized countries, gave us the first models of community mental health services.

In the cities dependence is not great sin. The frontier ethic which valued rugged individualism, inner direction and self-made heroes has become less functional in industrial societies. There is an increasing recognition that problems are very special and need expert help and that the society ought to develop that expertness and provide that help which is required without casting aspersions on those in need.

With increasing frequency, as people are being concentrated into urban communities, there is an attenuation of area kinship and tribal networks through which can flow exchanges of help in times of crises or supports for chronic distress. As a result social arrangements are being invented to serve as surrogates for the extended family: nursery schools, foster grandparents, bankers, mechanics, visiting nurses, natural childbirth classes, and mental health facilities. The nuclear family is essentially dependent, and it is possible to develop dependence appropriately according to circumstances. When we talk of the differences between rural and urban communities, what we really mean is differences in value systems and cultures. Cultures are made up of little cults and the newest psychiatric cult is that of rehabilitation. It is now thought that much mental illness is not curable but is readily amenable

to control. There is the possibility of reduction in severity of symptoms and distress and of restoring more appropriate social and interpersonal functioning.[3] Recognizing that mental illness is often accompanied by the social breakdown syndrome[4] leads to the development of resources which are specific to the kind and seriousness of the disability. The ability to invent special social prostheses and to assemble them into a spectrum of services is a major part of the new technology. This becomes apparent as one specifies the operations of the spectrum of services in the provision of continuity of care.

The services represent various levels of intervention: casefinding, outpatient, partial inpatient and total inpatient care. There are various responses and responding groups in each category.

The basic level of living and intervention is that of <u>intimates</u> - families, friends, fellow workers, neighbors, recreational participants and rather especially, one's self. A person must live with these, all of these, and to the extent that others are distressed, he is in trouble; they overreact either by avoidance or by too much caring.

At the second level of intervention are people who are designated as casefinders. Most of them do something else, but they are both carriers of the sense of normality and influential enough in the power network to be able to get attention. In a complex society these are doctors, ministers, nurses, social workers, employers, policemen, teachers, judges, bartenders, bankers and undertakers. If the behavior which distresses the intimates also is visible to the casefinders, they turn people in the direction of treatment services.

The third level of sustaining includes all-out patient services. Casefinders want to see their "cases" diagnosed and get to some "treatment." They

like doctors, lawyers, social workers, nurses and clinics, sometimes "quacks" and sometimes old and sometimes new agencies. There is a sense in which Ann Landers and Dear Abby personify the casefinders who wants someone to do something expert and practicable. They often say see "a doctor," or "a minister" or "a lawyer," expecting that the petitioner will receive good and appropriate help. The representatives of this level of intervention are requested to say what is wrong and what should be done. It is here that the much maligned "medical model" comes into full flower. There is a diagnosis made and a treatment planned. Many of the professional types who were casefinders are also diagnosticians and "treaters." Here is a wide discussion about what happens and what should happen.

In this country judges in our local courts tend to operate as diagnosticians and treatment planners, if not to a greater extent, then with greater power than others. It is not at all unusual that a judge with or without other professional help at all, diagnoses a mental illness and prescribes treatment: ninety days in a mental hospital or hospitalized until cured. The most prevalant form of treatment is outpatient psychotherapy which assumes that the network of intimates is adequate enough to allow for considerable tolerance while personal problems are worked out. Frequently there is a retreat from the urban complexity to the pastoral notions of self-determination which consoles the therapist more than the patient in these trying occasions. Instead at this diagnosis and treatment level the full variety ofresources can be used -- physicians, clinics, social agencies and psychologists.

For those times when the person needs a protective environment, a knowledge of the resources available and their potential for support of his remaining

abilities is more important. Even more important is a knowledge of how to develop resources which can be useful to both the patient and the community. We have seen many of these inventions and there will be more as the idea is accepted that it is all right to develop social prostheses for enduring disabilities. Day care centers, sheltered workshops, day and night hospitals, foster homes, group care homes and halfway houses (halfway in as well as halfway out) are examples of ways to deal with inadequacy without going to the extremes of dividing the person off from all of his usual or possible interactions.

Sometimes it is necessary to protect the "intimates" and the "disturbed" person from each other in a more restrictive sense of "total care." It is clear, however, that not as many people will be sent for total hospital care as we begin to realize the alternatives of the new technology. This of course does not imply the romantic idea that no one needs <u>total care</u>. There is evidence that some people need institutional care because of the severity and/or chronicity of their bizarre behavior. These are the people who are so socially disabled that they need a completely protective environment. For some this will mean life-time care while for others it will mean brief asylums during acute phases. Hospitals, sanitoria, mursing homes and enclosed communities provide this category of care.

The creation of a spectrum of services or social prostheses appropriate for various levels of social functioning is one of two major aspects of the new technology. The other aspect is continuity in patient care. This aspect of mental health technology is lagging. We develop resources but we do not organize them for maximum benefit. It is apparent that energy, perceptivity and imagination are given to the development of new specific services and it is just as apparent that there is no adequate technology as yet for achieving

continuity of care. The basic question remains unanswered: where is the responsibility? In the simple rural society it is with the patient and his family. In health care generally, it is up to the customer to choose his service, how much and where. This certainly has been the official policy of the American Medical Association. Anyone who looks at the health picture in the United States and particularly mental health, can see clearly the pitfalls of "caveat emptor." Other possibilities, however, do not seem either to work or to fit our cultural pattern. There is a search for authority with autonomy and it has been so far unsuccessful. The problem of continuity of care is not dissimilar from what is often called the urban crisis. There are lots of bits and pieces but no discernible and acceptable pattern.

Look for a moment at what continuity of care means. It means that a person in distress can count on having the right kind of treatment at the right time, and that there will be someone to guide him through his difficulties The spectrum of treatment options is now so great that no one person can be the authority on all its aspects; the complexity is such that no one person and no single set of professional skills will be sufficient to supervise the varied facilities and their uses. There is the need to change from the idea that some one will care for me," whether God, mother, or physician," to the idea that "the system will care for me."

European models of continuity of care are of some help in clarifying the difficulty. In Amsterdam the Department of Public Health, by more or less common consent, has the power to make all decisions about the use of resources and can, therefore, readily decide what service best fits the need of the patient at any time. This is true for all medical problems including psychiatric.

In England, on the other hand, the successful programs seem to depend on one individual who acts like a symphony conductor in his catchment area, pointing out the exact moment when a given resource should come into play. The difficulty of this approach is that some services and some professionals will not join the concert.[5] There are actually two dimensions to consider: one is the relations between organizations and the other is a process of articulating roles within and between organizations. Articulating related roles in separate organizations helps professionals jointly to confront problems chosen from common interests. For example, social workers in inpatient, semi-protective, and outpatient settings need to know one another and develop trust and respect for each other's judgments related to their social work responsibilities. Depending on where service is initiated, the same worker should have access to all levels of intervention as the patient is moved from one service to another. Another example is the psychiatrist who has been employed by a public mental health clinic and who consults to the local halfway house and the regional mental hospital. In some communities a position of county psychiatrist has been created and this new post has access to all mental health services through those offices in the organizations that are amenable to joint occupancy.

Stable and productive interorganizational ties require a system of norms to define role-set relationships and to regulate interaction. For example, it is common in the USA to maintain that the physician is always "top dog" in matters of health. However, much of what is appropriate for mental patients is not medical so that other professionals and nonprofessionals vie for a share in his authority. In this country we have relied on voluntary cooperatic but it does not work. As Aiken and Hage[6] have pointed out, people can cooperat

only when they are not in competition for support from the same limited pot, either money or prestige. Special policies and statutes which establish new programs can help to induce shared norms and the motivation to abide by them by requiring interdependence among members of the organizations involved. When people need the support of others to achieve their goals, they are more likely to cooperate. An example from the field of education is the required cooperation between community action agencies and local education agencies (LEAs) in order to get federal support for compensatory education programs.

Unfortunately, as local authorities are established for comprehensive care there is the possibility that they will become holding companies for the distribution of funds without having any impact on processual changes. Organizational patterns may take on a new look in order to meet requirements for federal aid and still keep a hidden agenda for using those funds to maintain equilibrium in the old systems. The alternative is difficult and foreboding. Rehabilitative approaches to mental illness which make use of an array of services demand we take a new look at our technology for service delivery. Much of our depth of knowledge has come from an era of specialization. We know a great deal about particular problems and have tended to organize our agencies and services according to our special interests. It would be easy to continue this way. But it is too much to ask the mentally ill and his family to find their way along a maze of specialized services, to be good diagnosticians so that they can locate the services essential to meet their needs. Helping with problems attendant upon a variety of social disabilities will require professional people to expand their traditional roles and spend their time in unfamiliar ways. If an agency seeks merely to fit some aspect of mental health care into its existing structure, the comprehensive program

will serve the needs of the agency more than the needs of the patient and his family. If this does happen, then clinics will continue to see the patient in terms of his suitability for middle class therapies; general practitioners in terms of his somatic symptoms; and mental hospitals in terms of his need for protective custody. This is playing the old game in spite of the new rule

A major obstacle to playing new games with the new rules is process inertia.[7] Inertia is that quality which causes things to remain at rest or in uniform motion unless acted upon by some external force. Process inertia in mental health organizations means that the way patients get processed tends to continue in the same patterns as originally organized and set in motion, and it takes a big push from some outside force to change the patterns of processing patients. The technical level[8] in service organizations maintains this inertia through such means as specialization, differentiation and narrowing of services, admissions procedures that insure selectivity of the right kind of patients, and referral of rejects to nonprofessional caretakers for vigilance and control.

Another source of resistance to collaboration among services to provide for continuity of care is professional control. Professionals in any given field constitute a group of peers who are qualified to judge each other's professional practice. One of the traditional values associated with psychoanalytic treatment is that the patient is free to choose the outcome; he may stay sick if he chooses. This is called self-determination. From the rehabilitative perspective, however, no one is free to impose his disability on others and responsibility for outcome is shared with the helping person. Furthermore, the professional shares this responsibility with others when the patient's needs require help elsewhere. To the extent that these other community resource

are used collaboratively, the professional becomes exposed and accountable to a wider group of peers who see his work, judge his performance and exercise some control over this professional conduct. Sharing responsibility with other means trusting their judgments and entrusting one's own to their scrutiny. When professionals in mental health work lack this trust, it is often rationalized as the "need to protect confidentiality." This is a conversation killer and a great obstacle to collaboration on behalf of the patient and his family.

Where then is the sanction to mandate interservice collaboration? It must, it seems come from some community power center: a person or a government or a voluntary organization which supercedes local agencies and professionals. Sometimes this sanction may come from a field respresentative or regional consultant, a mental health authority, or a health planning council. The essential characteristic is that it must not itself be competitive with those services or persons it coordinates.

What does this mean? First, it means reaching out to all persons and agencies competent to be helpful and arranging ways in which each can participate in the continuity of care. The general practitioner, the staffs of the public health department, the county welfare department, the general hospital, the counsellors, ministers, day care directors, and on and on, to name a few of the kinds of people involved.

Continuity of care can be achieved when the sanction for the use of power is not given to a person or an office, but to required skills whose use should be the prerogative of persons in appropriate positions. In the USA sharing organizational autonomy is almost against the law and certainly against the ethics. There have not been significant breakthroughs in organization of government or industry. But this is changing. There are now more planning

bodies, especially in health and environmental control, and these may indeed invent the technology for a delivery of mental health service which will answer the crucial need for continuity in patient care.

It is provision of specialized resources and orchestrations to coordinate them, then, that is the essence of the newly developing technology. With this specialization comes the probability of evaluation. When a highly specific program is developed, then its purposes are known and its achievement is discernible.[9] The basic orientation changes from an interest in treatment process as such to a concern for outcome in terms of more appropriate personal and social functioning. The goal is to maintain the patient at the least levels of sustaining while working toward returning him to a circle of intimates Evaluation becomes something more than useful feedback into the internal system on the efficiency of operations; it implies accountability to the community, broadly defined -- to citizens, legislators, recipients of service and to fellow professionals in all helping professions, across many disciplinary lines Broadening the base of accountability must overcome that process inertia which supports well-established procedures and resists change or even investigation.

Resistance to accountability reflects a lack of reciprocal trust of self and colleagues which would permit the use of an array of services according to patients' varied needs. Nothing is so difficult as sharing professional secrets with differently or less thoroughly trained people. This is, in part, because it is difficult to believe the other fellow can understand. But continuity of care which adds something to the traditional notion of referral and to the definition of inter- and intra-professional accountability, is dependent upon being able to share responsibility with those others who can and wish to share in treatment.

Even as we ask others to trust our judgments, this trust must be reciprocated, and if communication is developed adequately, then anyone's recommendation for patient care can be given consideration. In community mental health responsibility must be diffused. If it is not, the program fails In the carefully controlled English study by Sainsbury and Grad[10] it was shown that inadequately developed and used social services greatly reduce the effectiveness of a mental health program. If nurses in hospitals and public health nurses are not trusted with responsibility and authority, patients suffer. Moreover, in the foreseeable future large numbers of aides will be working with outpatients as well as inpatients and we must beware of making the same errors on the "outside" that we made on the "inside" when we turned over the "keeper's" task to the aides, downgraded the keeper's role as differentiated from the treatment role, and then blamed the aide for our many errors and failures.

The new demand for evaluation based on specifiable outcomes is threatening to many professionals and resistance to comprehensive health planning may be an attempt to maintain a feeling of euphoria. That is, anyone can discuss feelings without anxiety since there is no baseline, but no one willingly wants to be judged as he tries to predict his patient's future behavior. Yet it is the more or less of appropriate behavior that serves as the criterion for moving patients from one level of sustaining to another, for varying the intens of intervention as we try to provide for continuity in care over time.

With proper evaluation, failure become guides to improvement rather than graveyards of error. The promise that evaluative studies will lead to such improved results that accountability will be rewarding rather than frightening is the incentive for taking greater risks of failure by trusting others to share in the treatment tasks and opening up our own judgments for consumer and community review.

CONCLUSION

The new technology in mental health can have three main ingredients:

1) A spectrum of services. In recent years this aspect has been developed diligently and creatively.

2) Continuity of care. Here there is great dereliction; no one has designed the connections to provide the mentally ill person with the right service at the right time.

3) Evaluation. Studies have been disappointing largely because there is very little specific use of the services in a prescriptive sense. Evaluation needs to know what the system is, how it is used, and with what effects. The lack of any one of these three kinds of information reduces evaluation either to guesswork or statements of faith.

As the city's virtues of complexity and variety are widely recognized, disseminated and accepted, they may be applicable in small and even rural communities. Because of the greater maneuverability of small communities, they may be the locus of those greatly needed organizational breakthroughs which are essential for the implementation of the new technology of mental health care.

FOOTNOTES

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